Rheumatology New Patient History Form

Patient name: _____ Age _____
Last First MI

Birthdate: ___/___/___ Occupation: _____

Referred By: _____ □Physician □Self □Family □Friend □Other

Primary Care Physician (PCP): _____ Location: _____

Reason for present visit? _____

Date Symptoms Began? _____ Location of Pain? _____ Level of Pain on a scale from (1-10) _____

Worsening Factors: _____

Any Diagnosis given? _____

Any Treatment? _____

Rheumatologic History:

Diseases	Yourself	Relative Name/Relationship
Rheumatoid Arthritis		
Osteoarthritis		
Lupus or "SLE"		
Ankylosing Sondylitis		
Childhood Arthritis		
Others:		

Other Medical Problems (check-mark if "YES")

□ High Blood Pressure	□ Anemia	□ Stomach ulcer	□ Glaucoma	□ Cancer
□ Heart Problems	□ Kidney disease	□ Hepatitis	□ Cataracts	□ Tuberculosis
□ Diabetes	□ Emphysema	□ Jaundice	□ Stroke	□ HIV/AIDS
□ High Cholesterol	□ Pneumonia	□ Goiter	□ Epilepsy	□ Fractures
□ Other (Specify):				

Previous Operations

Type	Year	Reason

Family History

Number of Siblings _____ #Living _____ #Deceased _____; Number of Children _____ #Living _____ #Deceased _____

Any rheumatic diseases in the family, who and what _____

	Age if Living	Health	Age at death if deceased	Cause
Father				
Mother				

Do you smoke? □ Yes □ No □ Past – How long ago? _____ Number per day: _____; for how long _____

Do you drink alcohol? □ Yes □ No If Yes, what kind _____ Number per week _____

Do you use any recreational drugs? □ Yes □ No If Yes, please list _____

Drug Allergies: □ Yes □ No To What: _____

Type of Reaction: _____

Current Medications:

Name of Drug	Strength	Frequency	For how long
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Attach a list or write at the back of this page if more space is needed.

Systems Review

Date of last eye exam: ___/___/_____ Date of last Chest X-Ray: ___/___/_____ Date of last Tuberculosis Test: ___/___/_____

Please check any of the following problems listed, which have significantly affected you:

Constitutional
□ Recent weight gain, amount _____
□ Recent weight loss, amount _____
□ Fatigue □ Fever
□ Weakness

Eyes
□ Pain □ Redness
□ Itching
□ Dryness □ Loss of Vision
□ Double or blurred vision
□ Feel like something in the eye

Ears-Nose-Mouth-Throat
□ Ringing in ears
□ Loss of hearing
□ Nosebleeds □ Loss of smell
□ Sore tongue □ Bleeding gum
□ Sores in mouth
□ Dryness in mouth
□ Difficulty in swallowing

Cardiovascular
□ Pain in Chest
□ Heart murmurs
□ Irregular heart beat
□ Congestive heart failure

Respiratory
□ Shortness of breath
□ Difficulty in breathing at night
□ Cough □ Wheezing
□ Coughing of blood

Gastrointestinal
□ Nausea □ Vomiting
□ Stomach pain/heart burn
□ Increasing Constipation
□ Frequent Diarrhea
□ Blood in stools or black stools

Genitourinary
□ Difficult urination
□ Pain or burning on urination
□ Blood or pus or cloudy urine
□ Rash or ulcers
□ Discharge from penis/vagina

Skin and Breast
□ Redness □ Hives □ Rash
□ Sun Allergy □ Tightness
□ Nodules/Bumps □ Hair loss
□ Color changes of hands or feet in the cold

Neurological
□ Severe Headaches □ Dizziness
□ Passed out □ Memory loss
□ Sensitivity or pain of hands/feet
□ Restless legs at night
□ Night Sweats

Psychiatric
□ Anxiety □ Depression
□ Agitation □ Difficulty of sleep

Other
□ Swollen/tender glands
□ Bleeding tendency
□ Transfusion, when _____
□ Frequent infection
□ Excessive thirst

Musculoskeletal
□ Morning stiffness, How long _____
□ Muscle tenderness □ Weakness
□ Joint swelling/pain
List of joints affected in the last 6 mos:
_____
_____
_____
_____
_____
_____
_____
_____